# 2004 Benefit Summary Matrix for Kaiser Foundation Health Plan, Inc. AB 1401 Conversion Product

**This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on the plan's or insurer's site.**

| **Plan Name** | **Plan Contact Name and Phone Number** |
|---|---|
| Kaiser Foundation Health Plan, Inc. | Member Services 800-464-4000 |

**Coverage summary**

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| Eligibility requirements | An employee or member whose coverage under a group contract has been terminated by an employer who is eligible for individual conversion coverage. Such coverage is not required to be offered under the circumstances (*1) |
| The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside | Premiums charged by plans vary by region and age of subscribers. See "Premium Rate" tab for this plan. |
| When and under what circumstances benefits cease | Benefits cease due to:<br>Fraud;<br>Loss of eligibility;<br>Failure to pay premiums;<br>Nonpayment of any amounts due the Plan, Plan hospitals, a medical group or copayment due a plan provider.<br>Member may terminate by written notice to plan.<br><br>Benefits terminate for cause as follows:<br>Fraud-upon receipt of notice;<br>Loss of Eligibility-the last day of the month in which you are no longer eligible;<br>Failure to pay premium due-after 15 day notice;<br>Nonpayment of other charges- At least 15 days after receipt of written notice;<br>Voluntary termination by member-the first of the month following adequate notice to plan. |
| The terms under which coverage may be renewed | New sales are issued through the end of the calendar year. All accounts renew annually on January 1st. |
| Other coverage that may be available if benefits under the described benefit package cease | Subject to Medical Review, the individual may apply for Personal Advantage, unless benefits ended due to termination for cause, fraud, non-payment, etc. |
| The circumstances under which choice in the selection of physicians and providers is permitted | Members are encouraged to choose a primary care Plan Physician from a list of available Plan Physicians in the following specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. Members may change their primary care Plan Physician at any time. |
| Lifetime and annual maximums | No lifetime maximums;<br>Annual Out-of Pocket Maximum: $2,500 for one Member; $5,000 for Subscriber and all his or her Dependents |
| Deductibles | $250 calendar year pharmacy deductible on compounded drugs and brand name items |

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| **Benefits Summary (**2) & (***3)** | | **Co-payments** | **Limitation** |
|---|---|---|---|
| Professional Services | Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits. | | |
| | Primary and Specialty Care Visits (includes routine and urgent Care) | $25 per visit | |
| | Vision Exams | $25 per visit | |
| | Hearing Exams | $25 per visit | |
| | Scheduled Well Baby Visits (0 - 23 months) | $0 | |
| | Scheduled Prenatal Visit and first Post-Partum Visit | $0 | |
| | Family Planning | $25 per visit | |
| | Allergy Testing | $25 per visit | |
| | Allergy Injections | $5 per visit | |
| Outpatient Services | Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures. | | |
| | Outpatient Surgery | $100 per procedure | |
| | Voluntary Sterilization | $100 per procedure | |
| | Voluntary termination of pregnancy | $25 per procedure | |
| | Physical, Occupational, and Speech Therapy (including multi-disciplinary rehabilitation) | $25 per visit | |
| | Lab | $10 per encounter | |
| | Imaging (except MRI, CT, and PET) | $10 per encounter | |
| | MRI, CT, and PET, | $50 per encounter | |
| | Other Tests & Procedures | $10 per encounter | |
| | Dermatology (UV light treatment) | $10 per treatment | |
| | Health Education Classes – Individual | $25 per visit | |
| | Health Education Classes – Group | $0 | |
| Hospitalization Services | Inpatient and outpatient services, including, but not limited to room and board and supplies. | | |
| | Inpatient – Hospital (including maternity) | $200 per day | |
| | Inpatient - Multi-disciplinary Rehabilitation Services | $200 per day | |
| Emergency Health Coverage | Emergency room services at contracted and non-contracted facilities for medically necessary emergency services. | $100 per visit (waived if admitted) (If admitted, hospitalization | |

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| | | copayments apply) | |
| Ambulance Services | Emergency ambulance transport. | $100 per trip | |
| Prescription Drug Benefits | Medically necessary drugs prescribed by a physician.<br><br>100 Days Supply (Generic)<br>100 Days Supply (Brand)<br>Sexual Dysfunction Drugs | <br><br>$10<br>$35 after Deductible<br>50% Coinsurance after Deductible | Drugs, supplies, and supplements are covered when prescribed by a Plan Physician and in accord with our drug formulary guidelines. Certain drugs are covered only for a 30-day supply in a 30 day period.<br>Most brand name drugs are subject to a $250 calendar year deductible. |
| Durable Medical Equipment | Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies. | | |
| | Includes Durable Medical Equipment, Supplies, Prosthetic Devices, and Braces. Other items listed above may be covered under other benefit categories.<br><br>Items used during covered Hospital stay or Skilled Nursing Facility<br><br>Items used at home | <br><br>$0<br><br>Not covered except for a small number of items that are covered at 20% Coinsurance | Durable Medical Equipment is covered in accord with our DME formulary guidelines.<br><br>See Evidence of Coverage for additional information. |
| Mental Health Services | Inpatient and outpatient mental health services, including, but not limited to, mental health parity services for serious mental disorders and severe emotional disturbances for children.<br><br>Outpatient – Individual<br>Outpatient – Group<br>Inpatient | <br><br>$25<br>$12<br>$200 per day | <br><br>Up to a total of 20 individual and group therapy visits each calendar year<br>Up to 30 days per calendar year<br><br>Visit and Day Limits do not apply to mental health parity conditions |
| Residential Treatment | Transitional residential recovery services for chemical dependency | $100 per admission | up to 60 days per calendar year, not to exceed 120 days in a consecutive 5 year period |

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| Chemical Dependence Services | Substance abuse treatment or rehabilitation.<br><br>In the Hospital<br>Outpatient– Individual<br>Outpatient - Group<br>Transitional Residential Recovery Services | <br><br>$200 per day<br>$25 per visit<br>$5 per visit<br>$100 per admission | <br><br><br><br><br>up to 60 days per calendar year, not to exceed 120 days in a consecutive 5 year period |
| Home Health Services | Home health and hospice care services. (***4)<br>Hospice Care<br>Home Health Care | <br>$0<br>$0 | Part-time or intermittent home health covered up to:<br>• Up to 2 hours per visit<br>• Up to 3 visits per day<br>Up to 100 visits per calendar year |
| Custodial Care and skilled nursing facilities | Skilled Nursing care and skilled nursing facility services.<br><br>Custodial Care | $0<br><br>Not covered | 100 days per benefit period |

(*1)

(a) the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;
(b) coverage was terminated because the employee or member failed to pay amounts due the plan;
(c) the employee or member was terminated for cause as set forth in its evidence of coverage;
(d) the employee or member knowingly furnished incorrect information or otherwise improperly obtained benefits of the plan;
(e) the employer's insurance coverage is self-insured;
(f) the employee or member is covered or eligible for benefits under Title XVIII of the United States Social Security Act;
(g) the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
(h) the employee or member is covered for similar benefits under an individual contract or policy;

(**2) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

(***3) Percentage co-payments present a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage copayments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(****4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.